



Bright Futures Parent Handout 6 Month Visit

Here are some suggestions from Bright Futures experts that may be of value to your family.

Feeding Your Baby

- Most babies have doubled their birth weight.
- Your baby's growth will slow down.
- If you are still breastfeeding, that's great! Continue as long as you both like.
- If you are formula feeding, use an iron-fortified formula.
- You may begin to feed your baby solid food when your baby is ready.
- Some of the signs your baby is ready for solids
 - Opens mouth for the spoon.
 - Sits with support.
 - Good head and neck control.
 - Interest in foods you eat.

Starting New Foods

- Introduce new foods one at a time.
 - Iron-fortified cereal
- Good sources of iron include
 - Red meat
- Introduce fruits and vegetables after your baby eats iron-fortified cereal or pureed meats well.
 - Offer 1–2 tablespoons of solid food 2–3 times per day.
- Avoid feeding your baby too much by following the baby's signs of fullness.
 - Leaning back
 - Turning away
- Do not force your baby to eat or finish foods.
 - It may take 10–15 times of giving your baby a food to try before she will like it.
- Avoid foods that can cause allergies—peanuts, tree nuts, fish, and shellfish.
- To prevent choking
 - Only give your baby very soft, small bites of finger foods.
 - Keep small objects and plastic bags away from your baby.

NUTRITION AND FEEDING

How Your Family Is Doing

- Call on others for help.
- Encourage your partner to help care for your baby.
- Ask us about helpful resources if you are alone.
- Invite friends over or join a parent group.
- Choose a mature, trained, and responsible babysitter or caregiver.
- You can talk with us about your child care choices.

FAMILY FUNCTIONING

Healthy Teeth

- Many babies begin to cut teeth.
- Use a soft cloth or toothbrush to clean each tooth with water only as it comes in.
- Ask us about the need for fluoride.
- Do not give a bottle in bed.
- Do not prop the bottle.
- Have regular times for your baby to eat. Do not let him eat all day.

ORAL HEALTH

Your Baby's Development

- Place your baby so she is sitting up and can look around.
- Talk with your baby by copying the sounds your baby makes.
- Look at and read books together.
- Play games such as peekaboo, patty-cake, and so big.
- Offer active play with mirrors, floor gyms, and colorful toys to hold.
- If your baby is fussy, give her safe toys to hold and put in her mouth and make sure she is getting regular naps and playtimes.
- Put your baby to bed when she is sleepy but still awake.

INFANT DEVELOPMENT

Crib/Playpen

- Lower the crib mattress all the way when your baby begins to stand.
- Use a crib with slats close together— $2\frac{3}{8}$ inches apart or less.
- When your baby is in the crib, make sure the drop side is up.
- Don't use loose or soft bedding.
- Use a mesh playpen with weaves less than $\frac{1}{4}$ inches apart.

Safety

- Use a rear-facing car safety seat in the back seat in all vehicles, even for very short trips.
- Never put your baby in the front seat of a vehicle with a passenger air bag.
- Don't leave your baby alone in the tub or high places such as changing tables, beds, or sofas.
- While in the kitchen, keep your baby in a high chair or playpen.
- Do not use a baby walker.
- Place gates on stairs.
- Close doors to rooms where your baby could be hurt, like the bathroom.
- Prevent burns by setting your hot water heater so the temperature at the faucet is 120°F or lower.
- Turn pot handles inward on the stove.
- Do not leave hot irons or hair care products plugged in.
- Never leave your baby alone near water or in bathwater, even in a bath seat or ring.
 - Always be close enough to touch your baby.
- Lock up poisons, medicines, and cleaning supplies; call Poison Help if your baby eats them.

SAFETY

What to Expect at Your Baby's 9 Month Visit

We will talk about

- Disciplining your baby
- Introducing new foods and establishing a routine
- Helping your baby learn
- Car seat safety
- Safety at home

Poison Help: 1-800-222-1222

Child safety seat inspection:
1-866-SEATCHECK; seatcheck.org



American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

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Name: _____

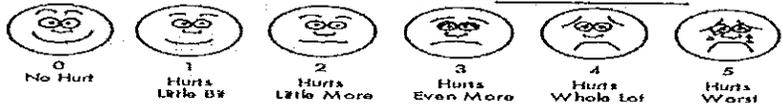
FMP and Sponsor Last Four: _____/_____

Date: _____

(Patient Label)

If this is the **FIRST** time you are filling in this form, please complete **ALL** areas.
If you have **ALREADY** completed it, please complete **SHADED** areas **ONLY**.

1. **No Allergies** Please list any allergies you have (drug, food, latex) _____

Clinic Use Only			
BP	/	HT	Visual Acuity: R 20/____ L 20/____ Both 20/____
HR		WT	Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of Pain _____
RR		HC	
TEMP		SpO2	

(Please complete information below: if filled out before, list only changes since the last visit.)

Chronic Medical Conditions (Circle all that apply)	Surgeries/Hospitalizations (Dates) (Circle all that apply)	Family History—(Parents, grandparents, siblings, aunts, uncles) (PLEASE STATE WHOM)	Medicines (PLEASE INCLUDE DOSAGE)
NO Medical Conditions Asthma Diabetes Hayfever/Allergies Other: _____	NO History of Surgeries Ear Tubes Tonsillectomy Adenoidectomy Appendectomy Circumcision Other: _____	Birth Defects Deafness before Age 5 Kidney Disease Post Partum Depression Early or Sudden Death to include SIDS Heart attack before age 50 High Blood Pressure High Cholesterol Hypertrophic Cardiomyopathy Long QT syndrome Arrhythmias Diabetes Mental illness Alcohol or Substance Abuse Genetic or Metabolic Disease Other: _____	Please list all prescribed medications including supplements, herbals and vitamins obtained Over the Counter <input type="checkbox"/> Infant Multivitamin 1 ml per day

BIRTH HISTORY-Complete for AGES NEWBORN TO 2 YEARS

Place of Birth: _____
 Birth weight? _____ # weeks pregnant at delivery? _____
 Prenatal complications No Yes describe: _____
 Group B Strep. (GBS) Positive Negative Don't Know
 Type of Delivery (check all that apply):
 Vaginal Forceps Vacuum-assisted C-section Breech
 Complications at birth?
 Jaundice * Yes No Phototherapy * Yes No Hip Click/Clunk * Yes No
 Other: _____
 Did your child receive the Hepatitis B vaccine at birth? Yes No Unsure

Newborn Metabolic Screen Submitted:

Yes No Don't Know
 Repeated
Baby's Hearing Screen:
 Passed Bilateral
 Repeat Needed
 Don't Know

Clinic Use Only - For Newborns-2 weeks
 Complete Risk assessment for Jaundice (Bili and Blood Type)

Source of Medical Information: Mother Father Patient Other: _____
 Any Hospitalizations, specialty care, or ER visits since your last appointment? No Yes: _____
 Would you say your child's Overall Feeling of health is? Excellent Very Good Good Fair Poor
 Are you or the patient currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid? Yes No Decline
 Are your child's immunizations up to date? Yes Unsure No

Does your child have a chronic medical or behavioral health problem, and/or physical disability? No Yes
 Is frequent follow-up support required for the above issues? No Yes
 Does your child require early interventions or special education services? No Yes
 Is your child enrolled in the Exceptional Family Member Program? No Yes

(Please complete Questions on REVERSE SIDE OF DOCUMENT)

Is your child In Day-Care
 Does anyone in the family smoke or is your child exposed to secondhand smoke? No Yes
 Who does the Child Live With? Parents Mother Father Other: _____
 Is Sponsor currently deployed: No Yes
 Is this visit deployment related: No Yes
 Does your child ride in a car with a car seat? Yes No

Tuberculosis Screening - Complete at 1, 6, 12, and 18 month Well Child Visit
 Yes No Unsure Has a family member or contact had tuberculosis?
 Yes No Unsure Has a family member had a positive tuberculin skin test?
 Yes No Unsure Was your child born in a high-risk country (countries other than US, Canada, Australia, New Zealand, or Western Europe)?
 Yes No Unsure Has your child traveled to a high risk country for more than one week (had contact with country residents)?

Lead Screening - Complete at 6, 9, 12, and 18 Month Well Child Visit
 Yes No Unsure Does your child have a sibling or playmate with Hx of lead poisoning?
 Yes No Unsure Does your child live in or regularly visit a house or child care facility built before 1950?
 Yes No Unsure Does your child live in or regularly visit a house or child care facility built before 1978 that has peeling/chipping paint or has been renovated or remodeled within the past 6 months?

What is your preferred method for learning: Verbal Written Visual Hands-On Other: _____
 Yes No - Do you or your child have learning/readiness needs?
 Yes No - Are there cultural or religious considerations that affect your child's healthcare?
 Yes No - Are you and your child enrolled in Secure Messaging/RelayHealth/MiCare?
****PLEASE PROVIDE A GOOD CONTACT NUMBER: _____**

Breastfeeding? Yes No How often? _____ Minutes per breast? _____ Concerns? _____
 Bottle feeding? Yes No Brand? _____ Ounces per feed? _____ How often? _____
 Number of wet diapers per day? _____ Stools per day? _____
 Circle if you have any concerns about the following (circle all that apply): Bowel movements / Constipation / Sleep problems

If Edinburgh Postpartum Depression Screen (EPDS) not attached.
 Mother please complete below questionnaire at 1week, 2 and 4 month Well Child visits.

Over the last 2 weeks, how often have you been bothered by any of the following?
 Little interest or pleasure in doing things? Not at all Several days More than half the days Nearly every day
 Feeling depressed or hopeless? Not at all Several days More than half the days Nearly every day

------(This section NOT for patient use)-----

Treatments orders for this visit - Ensure Patients Name and last four on Front of Document:

<input type="checkbox"/> Flu Swab	<input type="checkbox"/> Ear Irrigation	<input type="checkbox"/> CBC	<input type="checkbox"/> Chol Panel	<input type="checkbox"/> Billirubin (T/D)	<input type="checkbox"/> CXR
<input type="checkbox"/> RSV Swab	Left _____ Right _____	<input type="checkbox"/> UA	<input type="checkbox"/> HbA1c	<input type="checkbox"/> TsBill	<input type="checkbox"/> EKG
<input type="checkbox"/> Strep Screen/TCx	<input type="checkbox"/> Saline Bulb Suction	<input type="checkbox"/> CRP/ESR	<input type="checkbox"/> TSH,T4	<input type="checkbox"/> Monospot	
<input type="checkbox"/> Tussin Swab	<input type="checkbox"/> Motrin (PO) _____ mg	<input type="checkbox"/> BMP	<input type="checkbox"/> Iron Profile	<input type="checkbox"/> EBV Titers	
<input type="checkbox"/> Dex	<input type="checkbox"/> Tylenol (PO) _____ mg	<input type="checkbox"/> CMP	<input type="checkbox"/> Lead		
<input type="checkbox"/> EVALUATE FOR VACCINE UPDATE <input type="checkbox"/> PPD <input type="checkbox"/> Other _____					
<input type="checkbox"/> Immunizations - 2 Month - Pediarix (DTaP-IPV-HepB), Hib, PCV-13, Rotateq					

Well Child Developmental Screenings

1 Week (3-5 days)			1 MONTH			2 MONTH		
COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)			COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)			COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)		
If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit:								
<input type="checkbox"/> Eats well	<input type="checkbox"/> If upset, able to calm	<input type="checkbox"/> Lifts head and begins to push up when prone	<input type="checkbox"/> Follows your face	<input type="checkbox"/> Has started to smile	<input type="checkbox"/> Holds head erect for short period (when held upright)	<input type="checkbox"/> Turns and calms to your voice	<input type="checkbox"/> Recognizes voice of parents	<input type="checkbox"/> Diminished newborn reflexes
<input type="checkbox"/> Can suck, swallow and breath easy	<input type="checkbox"/> Follows parents with eyes	<input type="checkbox"/> Symmetrical movements	<input type="checkbox"/> Able to lift head when on tummy	<input type="checkbox"/> Indicates boredom when no activity change	<input type="checkbox"/> Coos		<input type="checkbox"/> Different crying for different needs	<input type="checkbox"/> Smiles
		<input type="checkbox"/> Looks for parents			<input type="checkbox"/> Self-comfort			
4 MONTH			6 MONTH			9 MONTH		
COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)			COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)			***COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)***		
If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit:								
<input type="checkbox"/> Pushes chest to elbows	<input type="checkbox"/> Sits briefly, leaning forward	<input type="checkbox"/> Sits well	<input type="checkbox"/> Good Head control	<input type="checkbox"/> Rolls over	<input type="checkbox"/> Crawls	<input type="checkbox"/> Symmetry in movements	<input type="checkbox"/> Uses visual exploration	<input type="checkbox"/> Pulls to feet with support
<input type="checkbox"/> Begins to roll and reach for objects	<input type="checkbox"/> Beginning to use oral exploration	<input type="checkbox"/> Peekaboo	<input type="checkbox"/> Responds to affection	<input type="checkbox"/> Uses a string of vowels (ah, eh, oh)	<input type="checkbox"/> Objects permanence	<input type="checkbox"/> Indicates pleasure or displeasure	<input type="checkbox"/> Beginning to recognize own name	<input type="checkbox"/> Looks at book
<input type="checkbox"/> Spontaneous expressive babbling	<input type="checkbox"/> Enjoys vocal turn taking	<input type="checkbox"/> Imitates sounds	<input type="checkbox"/> Social smile	<input type="checkbox"/> Shows pleasure from interaction with parents or others	<input type="checkbox"/> Points out objects	<input type="checkbox"/> Elicits social interactions		<input type="checkbox"/> Stranger anxiety
<input type="checkbox"/> Smiles spontaneously		<input type="checkbox"/> Seeks parent for comfort	<input type="checkbox"/> Can calm down on own					
12 MONTH			15 MONTH			18 MONTH		
COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)			COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)			***COMPLETE ATTACHED M-CHAT-R*** ***AGES AND STAGES QUESTIONNAIRE (ASQ)***		
If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit:								
<input type="checkbox"/> Waves bye-bye	<input type="checkbox"/> Tries to do what you do	<input type="checkbox"/> Helps in the house	<input type="checkbox"/> Tries to do what you do	<input type="checkbox"/> Helps in the house	<input type="checkbox"/> Laughs in response to others	<input type="checkbox"/> Cries when you leave	<input type="checkbox"/> Listens to a story	<input type="checkbox"/> Speaks 6 words
<input type="checkbox"/> Plays Peekaboo	<input type="checkbox"/> Says 2 to 3 words	<input type="checkbox"/> Knows names of favorite books	<input type="checkbox"/> Hands you a book to read	<input type="checkbox"/> Scribbles	<input type="checkbox"/> Points to 1 body part	<input type="checkbox"/> Speaks 1-2 words	<input type="checkbox"/> Follows simple commands	<input type="checkbox"/> Stacks 2 small blocks
<input type="checkbox"/> Babbles	<input type="checkbox"/> Bends down without falling	<input type="checkbox"/> Runs	<input type="checkbox"/> Tries to make the same sounds you do	<input type="checkbox"/> Walks well	<input type="checkbox"/> Walk up steps	<input type="checkbox"/> Looks at things you are looking at	<input type="checkbox"/> Puts blocks in a cup	<input type="checkbox"/> Uses spoon and cup without spilling most of the time
<input type="checkbox"/> Follows simple directions	<input type="checkbox"/> Puts block in a cup		<input type="checkbox"/> Bangs toys together	<input type="checkbox"/> Drinks from cup with very little spilling				

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

AHLTA was not accessible during this patient visit. Reviewed note & agree _____ *(Provider Initial)*

VISIT FOR: : Acute Well Child Visit 3-5 day/1 week 1 Month 2 Months 4 Months
 6 Months 9 Months 12 Months 15 Months 18 Months

HPI:

ROS: Check only symptoms that may apply to today's visit.

<input type="checkbox"/> Fever	<input type="checkbox"/> Cough	<input type="checkbox"/> Poor Weight Gain
<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Hearing Concerns
<input type="checkbox"/> Nasal Discharge	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Earache	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Pulling at the Ear(s)	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Snoring
<input type="checkbox"/> Eyes Discharge	<input type="checkbox"/> Decrease in Appetite	<input type="checkbox"/> Change in Bowel Habits
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Rash	<input type="checkbox"/> Excessive Thirst

NE	Examination:	Normal	Abnormal
<input type="checkbox"/>	General:	<input type="checkbox"/> Active/Alert/WN/WD/NAD/ not dysmorphic	<input type="checkbox"/>
<input type="checkbox"/>	Head/Neck:	<input type="checkbox"/> NCAT/AFOF/neck supple	<input type="checkbox"/>
<input type="checkbox"/>	Eyes:	<input type="checkbox"/> EOMI, RR X2, NI corneal reflex <input type="checkbox"/> no strabismus	<input type="checkbox"/>
<input type="checkbox"/>	R ear:	<input type="checkbox"/> NI pinna/ext ear canal <input type="checkbox"/> TM gray/NI landmarks	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	L ear:	<input type="checkbox"/> NI pinna/ext ear canal <input type="checkbox"/> TM gray/NI landmarks	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	Nose:	<input type="checkbox"/> Patent, No congestion/discharge	<input type="checkbox"/> Congested
<input type="checkbox"/>	Oropharynx:	<input type="checkbox"/> Pink, moist, no cleft or pit	<input type="checkbox"/>
<input type="checkbox"/>	Lungs:	<input type="checkbox"/> CTAB, no retractions, NI WOB	<input type="checkbox"/>
<input type="checkbox"/>	CV:	<input type="checkbox"/> RRR, no murmur, strong femoral pulses, cap refill < 2 sec	<input type="checkbox"/>
<input type="checkbox"/>	Abd:	<input type="checkbox"/> Soft, NT, no HSM, no masses, ni BS, no umbilical/inguinal hernia	<input type="checkbox"/>
<input type="checkbox"/>	Ext/Spine:	<input type="checkbox"/> NL, FROM, nontender, no edema, <input type="checkbox"/> no sacral dimple	<input type="checkbox"/> Sacral Dimple
<input type="checkbox"/>	Skin:	<input type="checkbox"/> No rash, No bruises	<input type="checkbox"/> Jaundice
<input type="checkbox"/>	Hips:	<input type="checkbox"/> Full ROM, <input type="checkbox"/> Neg Barlow <input type="checkbox"/> Neg Ortolani	<input type="checkbox"/> Hip click <input type="checkbox"/> Hip clunk
<input type="checkbox"/>	Neuro:	<input type="checkbox"/> Normal tone/strength/symmetry	<input type="checkbox"/>
<input type="checkbox"/>	Genitalia:	<input type="checkbox"/> NI female/no adhesions <input type="checkbox"/> NI male, Testes down B/L	<input type="checkbox"/>
<input type="checkbox"/>	Other findings:	<input type="checkbox"/>	<input type="checkbox"/>

LABS/X-RAYS: Hip U/S Spine U/S

A/P : Well baby: normal growth & development for age
 400 IU Vitamin D supplement/day Infant Multivitamin 1 ml per day Triple paste to diaper area Q diaper change

F/U: at next well child visit at ___ months, or sooner if parental concerns
 Patient and/or parent verbalizes understanding of treatment and plan
 Anticipatory guidance/Prevention handout provided

Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: _____

Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____

Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
- As much as I always could
 - Not quite so much now
 - Definitely not so much now
 - Not at all
2. I have looked forward with enjoyment to things
- As much as I ever did
 - Rather less than I used to
 - Definitely less than I used to
 - Hardly at all
- *3. I have blamed myself unnecessarily when things went wrong
- Yes, most of the time
 - Yes, some of the time
 - Not very often
 - No, never
4. I have been anxious or worried for no good reason
- No, not at all
 - Hardly ever
 - Yes, sometimes
 - Yes, very often
- *5. I have felt scared or panicky for no very good reason
- Yes, quite a lot
 - Yes, sometimes
 - No, not much
 - No, not at all
- *6. Things have been getting on top of me
- Yes, most of the time I haven't been able to cope at all
 - Yes, sometimes I haven't been coping as well as usual
 - No, most of the time I have coped quite well
 - No, I have been coping as well as ever
- *7. I have been so unhappy that I have had difficulty sleeping
- Yes, most of the time
 - Yes, sometimes
 - Not very often
 - No, not at all
- *8. I have felt sad or miserable
- Yes, most of the time
 - Yes, quite often
 - Not very often
 - No, not at all
- *9. I have been so unhappy that I have been crying
- Yes, most of the time
 - Yes, quite often
 - Only occasionally
 - No, never
- *10. The thought of harming myself has occurred to me
- Yes, quite often
 - Sometimes
 - Hardly ever
 - Never

Administered/Reviewed by _____ Date _____

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

²Source: K. L. Wisner, B. L. Parry, C. M. Plontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Edinburgh Postnatal Depression Scale¹ (EPDS)

Postpartum depression is the most common complication of childbearing.² The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt *during the previous week*. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)

Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)

Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30

Possible Depression: 10 or greater

Always look at item 10 (suicidal thoughts)

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Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

²Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199



Ages & Stages Questionnaires®

6 Month Questionnaire

5 months 0 days through 6 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____ If baby was born 3 or more weeks prematurely, # of weeks premature: _____

Baby's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____

Relationship to baby:
 Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Baby ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

Notes:

COMMUNICATION

- | | YES | SOMETIMES | NOT YET | |
|---------------------------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|-----|
| 1. Does your baby make high-pitched squeals? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. If you call your baby when you are out of sight, does she look in the direction of your voice? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. When a loud noise occurs, does your baby turn to see where the sound came from? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your baby make sounds like "da," "ga," "ka," and "ba"? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |

COMMUNICATION TOTAL _____

GROSS MOTOR

- | | YES | SOMETIMES | NOT YET | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|-----|
| 1. While your baby is on his back, does your baby lift his legs high enough to see his feet? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. Does your baby roll from his back to his tummy, getting both arms out from under him? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. When you put your baby on the floor, does she lean on her hands while sitting? <i>(If she already sits up straight without leaning on her hands, mark "yes" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |



GROSS MOTOR (continued)

5. If you hold both hands just to balance your baby, does he support his own weight while standing?



YES	SOMETIMES	NOT YET	___
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

6. Does your baby get into a crawling position by getting up on her hands and knees?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

GROSS MOTOR TOTAL ___

FINE MOTOR

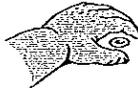
1. Does your baby grab a toy you offer and look at it, wave it about, or chew on it for about 1 minute?

YES	SOMETIMES	NOT YET	___
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

2. Does your baby reach for or grasp a toy using both hands at once?

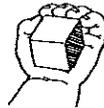
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

3. Does your baby reach for a crumb or Cheerio and touch it with his finger or hand? (If he already picks up a small object the size of a pea, mark "yes" for this item.)



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

4. Does your baby pick up a small toy, holding it in the center of her hand with her fingers around it?



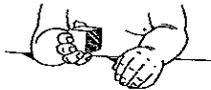
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

5. Does your baby try to pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion, even if he isn't able to pick it up? (If he already picks up the crumb or Cheerio, mark "yes" for this item.)



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

6. Does your baby pick up a small toy with only one hand?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

FINE MOTOR TOTAL ___

PROBLEM SOLVING

1. When a toy is in front of your baby, does she reach for it with both hands?

YES	SOMETIMES	NOT YET	___
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

2. When your baby is on his back, does he turn his head to look for a toy when he drops it? (If he already picks it up, mark "yes" for this item.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

3. When your baby is on her back, does she try to get a toy she has dropped if she can see it?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

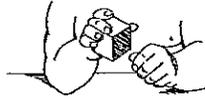
PROBLEM SOLVING (continued)

4. Does your baby pick up a toy and put it in his mouth?



YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

5. Does your baby pass a toy back and forth from one hand to the other?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

6. Does your baby play by banging a toy up and down on the floor or table?

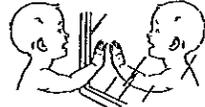


<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

1. When in front of a large mirror, does your baby smile or coo at herself?



YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

2. Does your baby act differently toward strangers than he does with you and other familiar people? (Reactions to strangers may include staring, frowning, withdrawing, or crying.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

3. While lying on her back, does your baby play by grabbing her foot?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

4. When in front of a large mirror, does your baby reach out to pat the mirror?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

5. While your baby is on his back, does he put his foot in his mouth?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

6. Does your baby try to get a toy that is out of reach? (She may roll, pivot on her tummy, or crawl to get it.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

PERSONAL-SOCIAL TOTAL ___

OVERALL

Parents and providers may use the space below for additional comments.

1. Does your baby use both hands and both legs equally well? If no, explain:

YES

NO

2. When you help your baby stand, are his feet flat on the surface most of the time?
If no, explain:

YES

NO

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain:

YES

NO

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain:

YES

NO

5. Do you have concerns about your baby's vision? If yes, explain:

YES

NO

6. Has your baby had any medical problems in the last several months? If yes, explain:

YES

NO

7. Do you have any concerns about your baby's behavior? If yes, explain:

YES

NO

8. Does anything about your baby worry you? If yes, explain:

YES

NO



6 Month ASQ-3 Information Summary

5 months 0 days through
6 months 30 days

Baby's name: _____ Date ASQ completed: _____

Baby's ID #: _____ Date of birth: _____

Administering program/provider: _____ Was age adjusted for prematurity when selecting questionnaire? Yes No

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	29.65		●	●	●	●	●	●	●	●	○	○	○	○	○
Gross Motor	22.25		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	25.14		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	27.72		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	25.34		●	●	●	●	●	●	●	○	○	○	○	○	○

2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- | | | | | | |
|----------------------------------------------------------------|-----|------------|------------------------------------------|-----|----|
| 1. Uses both hands and both legs equally well?
Comments: | Yes | NO | 5. Concerns about vision?
Comments: | YES | No |
| 2. Feet are flat on the surface most of the time?
Comments: | Yes | NO | 6. Any medical problems?
Comments: | YES | No |
| 3. Concerns about not making sounds?
Comments: | | YES | 7. Concerns about behavior?
Comments: | YES | No |
| 4. Family history of hearing impairment?
Comments: | | YES | 8. Other concerns?
Comments: | YES | No |

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the baby's total score is in the area, it is above the cutoff, and the baby's development appears to be on schedule.
If the baby's total score is in the area, it is close to the cutoff. Provide learning activities and monitor.
If the baby's total score is in the area, it is below the cutoff. Further assessment with a professional may be needed.

4. **FOLLOW-UP ACTION TAKEN:** Check all that apply.

- Provide activities and rescreen in _____ months.
- Share results with primary health care provider.
- Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): _____
- Refer to early intervention/early childhood special education.
- No further action taken at this time
- Other (specify): _____

5. **OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						